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Suicide:Psychoanalytic and Medicolegal Aspects

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I. SEVERAL PERSONS IN ONE—THE "INTROJECTION TYPE"

The humorist, Donald Robert Perry Marquis, wrote in 1935 the strange modernistic stanza:

> "A suicide is a person who has
> considered his own case and decided
> that he is worthless and who acts
> as his own judge, jury and executioner
> and he probably knows better
> than anyone else whether there is justice
> in the verdict."

Marquis believed, therefore, that the suicide acts out four roles—those of the judge, jury (twelve people condensed into one), executioner, and defendant. This self-appointed quartet can be augmented by a most important duo—the vociferous district attorney, demanding a death verdict, and the counsel for the defense, who is mute and ineffective.

There is intuitive knowledge in the satirist's remark: One cannot combine all four or six functions, respectively, in one person without making out of a fair trial—a mockery. This lack of objectivity is essential to the self-imposed suicide verdict. The important point is that in the disguise of a bitter joke the satirist sensed that more than one "person" is acting, intra-psychically,[1] in the suicide.

The rather popular subdivision into so many "persons" is, of course, a simplification to make the point clear. Scientifically speaking, the unconscious departments of the personality—Id,[2]

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1. *Intrapsychically*: synonym for unconsciously.

2. *Id*: an analytic term denoting that part of the unconscious which harbors repressed wishes. The term was first used by Nietzsche who spoke about "Das Es." "Es" means in German "it." (*It* snows, *it* rains.) Later "it" was latinized and thus "the Id" introduced as technical term.

Super Ego,[3] and Ego[4] are rather impersonal. "Id" denotes the department of repressed wishes, Super Ego, the inner conscience, unconscious Ego, a mediator between both. To translate Marquis' terminology, judge, jury and district attorney stand for the inner conscience; executioner, for the Ego; the silenced lawyer for the defense, for another part of the immobilized Ego, too.

Psychiatric-psychoanalytic experience confirms this assumption. It is known, since Freud's studies on "Mourning and Melancholia" (1916) that the suicide kills, not himself, but a person who deeply disappointed the suicide candidate and with whom the latter has subsequently unconsciously identified himself. Therefore, every suicide is—psychologically speaking—murder. We can state that still another "person" is present at the pre-suicidal mock trial—the other victim amalgamated with the suicide.

The problem is not quite understandable without going into details of the psychologic conception that *intrapsychically* Mr. X, the man who actually commits suicide, is not the person killed, but Mr. Y, with whom Mr. X identified himself.[5] This presupposes some knowledge of psychiatric-psychoanalytic conceptions of depressive psychotic states. It is a clinical fact that a very large group—perhaps the largest group—of all seriously intended and executed suicides belongs in this category.

In contrast to the wide experience psychoanalysis has at its disposal in the case of neuroses, our knowledge of manic-depressive psychoses is relatively limited; relatively few cases have been treated.

A manic-depressive psychosis (cyclothymia) is characterized by alternating phases of deep depression and exaggerated gaiety. For a few months the depressive psychotic is depressed, sleepless, without appetite, full of self-belittlement and self-accusations—in fact, he sees everything blackly. His future is, so he claims, hopeless: He will starve. He accuses himself of the most grotesque crimes or exaggerates harmless incidents from his past into "unforgivable sins." In this phase there is great danger of suicide. After some months, the patient comes out of this stage and some time later may become "manic." In this phase of the illness he sees everything in just the opposite light. He is gay, unperturbed by reality, jocular,

3. *Super Ego*: an analytic term denoting the unconscious part of the conscience.

4. *Unconscious Ego*: an analytic term denoting a specific part of the unconscious, coping with contradictory "Id"-wishes and "Super Ego"-reproaches. The neurotic symptom, for instance, is produced by that part of the unconscious.

5. Identification and introjection are synonymous.

constantly changing his interests, hectically looking for entertainment, without inhibitions sexually, flighty in his ideas. This phase passes, too, and the depressive cycle repeats itself after some time. Not all psychotics go through the whole cycle. Some repeat regularly the depressive state only, while others experience other variations.

Let us begin our attempt to understand this puzzling depressive phase of the psychosis with a consideration of the external precipitating causes of the disease. There are a whole series of these which, however, may always be reduced to two: threatened or actual loss of a beloved person and situations in which the patient's incapacity for love may be clearly established. Naturally, inner events do not always appear directly on the psychic surface and frequently the facts can be established only through psychoanalysis.[6] One should not allow oneself to be misled by the accounts given by the patient and his relatives, for they often bring forward all sorts of rational reasons, such as divorce, loss of the boy (girl) friend, change of residence or occupation, loss of a so-called "aim in life," the necessity of setting up one's own household, et cetera. Only when we draw out what is hidden behind the particular, sometimes commonplace, reason offered us, can we see that the two impelling factors above mentioned really apply—the loss of object and the establishment of one's own incapacity to love. The road to the loss of the love object is frequently quite circuitous and more or less along the lines in the following formula: "If X or Y really loved me, he would not have let me get into this or that painful situation." Frequently, the symbolic, unconscious meaning of the disappointment must be brought out by analysis. Further below will be discussed a woman writer who fell ill of a psychotic depression[7] in connection with the loss of a . . . dog!

Assuming for the sake of argument that the loss of object is as important as suggested for the inner motivation of the psychotic depressive phase, further clinical experience shows that the illness itself represents a complicated attempt to deny this loss. Freud has shown that the lost object is unconsciously introjected (identified with) and that the strange *self-accusations* of a patient of this type are at bottom *accusations* of the introjected object. Expressed dif-

6. *Psychoanalysis*: a medical-psychiatric science created by Sigmund Freud. Analysis assumes that the decisive motives for human actions are regulated by the unconscious.

7. *Psychotic depression*: a symptom and sign of manic-depressive psychosis. The term "psychotic" depression is used for the purpose of differentiation from neurotic depression.

ferently, the sick person identifies himself with the unfaithful object and treats this internalized (that is, introjected) object with the greatest aggression. Thus, basically, the frequent *suicide of the depressive* is, psychologically, essentially the *murder of the unfaithful object.* It is often found that the accusations which the patient now makes of himself have previously been directed by him toward someone else close to him, by whom he has been deeply hurt. For example, a depressed woman may accuse herself of unfaithfulness, selfishness and immorality, but analytic investigation shows that she formerly made these accusations of her husband.

All this sounds highly theoretical. It becomes clearer just as soon as we draw upon clinical experience. Let us begin with a case reported by Dr. Federn. This case[8] is particularly interesting since, owing to time and surroundings, it was completely free of the influence of the Freudian work which first described the mechanism of introjection in manic-depressive states. Thus, the usual objections to analysis, such as "ex-post-facto interpretations" and "far-fetched connections," cannot be raised here.

The patient fell ill of a depressive psychosis when she was thirty-four years old. She was married and the mother of two children. From the time of early youth she was easily excitable, and suffered during the period of her engagement from an hysterical loss of appetite. Upon marrying she underwent a grave case of vaginism which was treated surgically. Despite considerable sexual intercourse, she remained frigid. A change in situation forced the husband to live in some provincial place which could be reached only with difficulty. The journey took twenty-four hours; the schools were unsuitable; living and especially climatic conditions were unhealthful; so he left his family behind in the city. Since he himself often had to return home, his wife approved of the separation, which made possible an improvement in their economic position. During the period of separation, her nervous condition, consisting at this time primarily of hypochondria,[9] headaches, intestinal disturbances, et cetera, grew no worse; on the contrary, it improved somewhat.

Then the patient received an anonymous letter from the town in which her husband resided, stating that he was living with a young woman, his bookkeeper, and demanding that an end be put

8. The History of a Case of Melancholia (1923) 9 Int. Z. f. Psychoan. 201.
9. *Hypochondria*: a neurotic disease characterized by painful sensations in different organs without organic foundation.

to the "scandal." Without announcing her coming, she immediately set out with her children for that town and actually found a young person living and keeping house in her husband's residence. Both denied any intimate relationship, or relationship of any sort. Since the bookkeeper was supposed to be indispensable to the husband's new business, the wife had to suffer her to retain her post, but she did compel her to leave the house. She herself remained in the town despite its harmful climate, but after what had happened refused to resume marital relations with the husband.

The younger son took seriously ill and they were told he must go to the seashore for recovery. The patient and the two children thereupon went to a seacoast resort. There she met a young man with whom she engaged in an extensive flirtation which did not, however, lead to sexual relations. After her return she continued a secret correspondence with him. At the beach she had had taken for him a picture of herself in a bathing suit. The husband found the photograph, as well as a friendly postcard, and now began to play the aggrieved party. The marriage seemed to be finally shattered. Nevertheless, the wife manifested not a sign of the old nervousness; in fact, she seemed better than before. The town was, however, really a menace to health. She eventually contracted typhoid fever, for which she was given poor medical treatment and insufficient care until she was in extreme danger of her life. Upon recovery, she found herself reduced to a mere skeleton and without her former strikingly beautiful hair.

Now she sank into a heavy psychotic depression which led her to a number of sanitoria and psychiatric institutions. The illness began with unbounded grief over her lost hair. She spoke, or rather screamed, of nothing else and could not be torn away from the mirror, into which she would stare fixedly for hours and then throw herself to the ground weeping loudly: "My hair, my hair, I want my hair back." At the sanitorium she would refuse to take food, weep uninterruptedly and speak only of her hair, the loss of which, she said, she could not possibly survive. At a somewhat later stage, these lamentations over her hair were supplemented by a flood of self-reproach and self-degradation, as well as by boundless praise of her husband: "I am the worst creature in the world and have the best husband, whom I have mistreated as long as I have known him! He would be quite right to leave me!" She wanted to kill herself in order not to stand in the way of his happiness. "He has sacrificed himself for me long enough. He is no mere human

being; he is an angel in his goodness, and I am the most wretched creature in the world!" She became subject to suicidal attacks, mercilessly scratched her entire body and was not able to sleep at all: "I always have to think of how to make up for my sins, that's what keeps me from sleeping," et cetera. After a few months, her condition improved and finally she was discharged to the care of her family. Her mother then died of a sudden illness. The death caused deep pain but did not produce any self-reproaches of a serious kind.

During a family conference, months after her discharge, a noteworthy scene took place, for the sake of which the case is described. The wife heaped a mountain of reproaches upon her husband. She claimed that there hadn't been a single good hour in her apparently happy marriage. "You have always been a bad husband and a bad father! All these years I have sacrificed myself for you and never betrayed to anyone how much you have made me suffer." The husband defended himself: "You see, she still is not mentally responsible. Everything bad which she now says about me she said *of herself* when she was ill—the same reproaches, almost *word for word!*" To this the wife replied: "Yes, but then I was ill. *I meant you but named myself.*"

Naturally this example becomes intelligible only with Freud's description of the process of introjection[10] in manic-depressive states. The intuitive grasp of the situation which the patient had in the case cited would surely have remained unnoticed and unpublicized, had not the attention of psychiatrists been drawn to this phenomenon by Freud's fundamental discovery. Aside from this, however, we meet here and there cases of pronounced psychotic depression in which the process of the loss and introjection of the love-object is recognizable even without psychoanalysis. To be sure, such quick understanding of the psychological connection has become possible only since Freud drew attention to the basic principles.

A case of Dr. Elekes belongs here. A patient was sent to an institution because of psychotic depression. She repeatedly gave expression to self-accusations of stealing. In reality, she had never committed a theft. Her father, however, with whom she was living and to whom she, an unmarried daughter, was deeply attached, had been arrested for theft some time before. It was in connection with this event, which not only separated her from her father in real fact but also brought about a deep psychic reaction in the direction

10. *Introjection*: an analytic term denoting identification.

of alienation from her father, that the depressive disturbance broke out. The loss of the beloved person was followed immediately by introjection. We are thus dealing with a sort of desperate refusal to give up the object.

K. Menninger gives a very convincing example:[11] "A woman of thirty-five, of unusual capabilities, had manifested all her life tendencies indicative of strong oral-erotic cravings.[12] This cannot be better summarized than in the words of her own sister, who wrote her at one time during her analysis: 'You must realize, my dear sister, that you frighten your lovers away by loving so much. Your love is simply engulfing, devouring. You cannot eat your love like a cake, you know. At least, if you do, you can't expect to go on having him.' As is so often the case with such individuals, the poor woman had a propensity for selecting lovers whom circumstances made it quite impossible for her ever to possess. One of these, with whom she was deeply in love during a portion of her analysis, had a surname something like Allendorf and was usually referred to as 'Al'. Shortly after her separation from him (at his instigation) this patient attempted suicide by taking an overdose of the drug allonal. As she later told, just before the attempt she had had a dream in which she and a group of men which represented the analyst, the lover Allendorf, her father, her brother, of whom she was very jealous, and some others, were in a car which was wrecked, and all killed except her. 'Yes', she said, quite offhandedly, 'they were killed, *Al and All'*. Spoken rapidly in English, 'Al and All' sounds exactly like *allonal*. It was immediately apparent that in attempting to kill herself with the drug allonal, she was also carrying out the devouring of her lover and the other disappointing males, which was so apparent in all her actions that even her naive sister had detected it. Thus she obtained Al, in spite of his flight, by oral incorporation, and simultaneously destroyed him by the same method, and pari passu she attempted to destroy him in that she made a destructive attack upon herself, in whom Al had been (was being) incorporated."

The next example pertains to the woman writer, reported by H. Deutsch.[13] Before she fell ill, the fifty year old patient had

11. Psychoanalytic Aspects of Suicide (1933) 14 The Int. Journ. of Psychoan. 381.

12. *Oral-eroticism*: an analytic term denoting pleasurable sensations in the mouth-zone. Analytic theory assumes, for instance, that sucking is not only a caloric necessity but a pleasure, as well.

13. Psychoanalysis of Neuroses, Int. Psycho. Verlag (1930) 170.

worked cheerfully and had been quite sociable; in recent years, however, she had undergone changes in her entire personality. She shut herself off more and more from intercourse with people, but went about her profession for a time until an acute outbreak so worsened her condition that she had to be sent to a sanitorium. There the illness made rapid headway. The patient sank into a deep depression apparently centering about one single fearful thought, to this effect: She was undressed and lying in bed, when she was trust out upon the street and there, alone and deserted, left to die a horrible death. Sometimes she would give expression to this fear with complete apathy, at other times she would urge that it be done "rather sooner than later," and at still other times she would scream for help in intense delirious anguish: "They're coming! Don't let them take me! Have pity on me!" At intervals, she would always assert that she did not deserve anything else, that it was quite right that she be punished so gruesomely. When these self-accusations were looked into a little more closely, she had nothing more serious to offer than quite inconsiderable, everyday errors. The patient believed that she knew for certain and precisely that her illness had set in with the loss of her little dog, the "one and only," the dearest of her possessions. She had never found that dog again and as a consequence fell into a depression which gradually took on a psychotic coloring. Even before this the patient had suffered for many years compulsive symptoms which she kept secret, so that no one in her immediate surroundings had any inkling of them. The patient's entire pre-psychotic character bore the typical stamp of reaction formation.[14]

Intense jealousy of a very beautiful and gifted sister, eight years younger, remained quite conscious in her childhood memories. But her hatred of and death wishes against the sister were afterward buried deeply under the reactive feeling of tender, provident sisterly love. This transformation set in when the patient, after the death of her mother (which occurred in the patient's twelfth year), took over her mother's role in relation to her much younger sister. Toward this sister, the patient adopted an attitude of ascetic renunciation "of everything"—toward the very same sister she had formerly hated so ardently.

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14. *Reaction-formation*: an analytic term denoting the unconscious transformation of one psychic tendency into the opposite under pressure of guilt. The sense of shame, for instance, is a "reaction formation" built up against childlike exhibitionism. Another example is pity: as "reaction formation" against childlike cruelty.

In her eighteenth year, she fell ill of compulsive-neurotic symptoms[15] with typical compulsive ceremonial.[16] Everything she did she had to repeat so many and so many times. "Otherwise something will happen to my beloved sister," an inner voice would threaten. In this fear her original aggressive intentions toward her sister were carried out. On the psychic surface, the masochistically[17] manifested love that quite dominated her consciousness permitted the aggressive thoughts to appear in consciousness only in the form of fear. Apparently this overcompensation did not succeed in completely appeasing the feeling of guilt, since the inner conscience had knowledge of the repressed aggressive wishes and forced the compulsive-neurotic ceremonial as defense.

When the patient was twenty-one years old, her father died and the difficult financial situation in which she and her sister found themselves compelled her as the elder of the two to get a job and work hard at it. She thus had to renounce her ambitious dreams of becoming a great author and take upon herself, in the irksome work of a stenographer, a conscious though voluntary sacrificial burden on behalf of her younger sister. She now surrounded her ward with the most tender and loving care. The compulsive-neurotic symptoms disappeared. It might be conjectured as an explanation that the difficulties of her life and her sacrificial renunciation brought so much masochistic satisfaction that her aggressive impulses toward her sister were satisfied in being turned toward herself. Neurotic[18] torment was thus replaced by real torture —a well-known fact to which the seemingly "spontaneous" recovery of many neurotics suffering from compulsions may be traced.

15: *Compulsive-neurotic symptoms*: a psychiatric term denoting an inner compulsion, for instance, knocking on wood, touching an object three times, et cetera. If these neurotics do not follow their compulsion they are terrified lest "something terrible" should happen to them or to their family.

16. *Compulsion ceremonials*: a stabilized and formalized compulsion which is carried out after specific self-imposed rules.

17. *Masochism*: a psychiatric term introduced by Krafft-Ebing, denoting the opposite of sadism. In preparing his 'Psychopathia sexualis" Krafft-Ebing was confronted with the fact that certain perversions had as their aim the wish to endure pain. An example is a man who achieves sexual pleasure by being beaten by a woman. On the lookout for a term which would parallel the etymology of "sadism," which, in turn, was taken from Marquis de Sade, Krafft-Ebing chose a writer who described at that time of his novels the pleasure of pain. His name was Sacher-Masoch, hence "masochism." Psychoanalysis accepted the term, making, however, a clear-cut distinction between *perversion* masochism where pain is *consciously sought*, and *psychic* masochism. The latter term denotes an *unconscious* wish to be tortured, mistreated, deprived. Perversion masochism and psychic masochism are different entities.

18. *Neurosis*: a psychiatric term meaning illness of the unconscious part of the personality.

That which now came to her sister in emotional relations had already, one might say, been purified, freed of the negative component of the ambivalence-conflict.[19] Her self-love, once so deeply injured through her sister, now achieved satisfaction, even though along a false path. The patient abandoned the struggle, but sought to fulfill and accomplish in her *sister* everything *she* had dreamed of but could not attain for herself. A narcissistic identification[20] of this sort occurs very frequently in the relationship of parents to children. In this patient it arose on a soil already diseased, as a defense process the success of which might maintain the appearance of psychic health for a time but in further course must necessarily end disastrously.

The two sisters lived together for a number of years in complete seclusion, the elder one devoted entirely to the masochistic sacrifice of her work, the younger sunk in tedious, worthless playing at author. Both were waiting for the great day when the work of the younger sister's "genius" would finally be recognized. This mode of existence of the two girls, bound to each other by an overstrong bond, was unexpectedly in terrupted when the younger one married. The "ungrateful" sister left the older one without much scruple and went with her husband to live in a foreign country. The patient bore the separation calmly and worthily, even seeming to rejoice at her sister's good fortune, though she remained behind in solitude. She went her way neglected and unsociable, but at the same time managed to achieve success in literary work. After the loss of her sister, the patient took a little dog into the house. One day the dog ran off and the woman spared neither pains nor expense in trying to recover it—but in vain. At this point the heavy depressions set in. The disproportion between the actual occasion (loss of the dog) and the depth of the depression astonished the patient herself. Unconsciously, however, the harmless dog was plainly a substitute-object for the lost sister: its loss revived the deep grief that the patient had kept hidden in herself after the loss of the sister.

In the further course of the treatment, there soon emerged behind the patient's very sensible conduct at her separation from her

19. *Ambivalence*: a psychiatric term coined by the Swiss psychiatrist Bleuler. It denotes: love *and* hate toward the *same* person at the *same* time. Love, in this connection, can be called the positive, hatred the negative component of the ambivalence-conflict.

20. *Narcissistic identification*: identification with a person on the basis of traits similar to those which the person performing the identificaton harbors himself.

sister the bitterest sort of reproaches against the unthankful one, the recurrence of deep aggressive feelings of revenge toward the sister, once hated, then beloved and finally branded as unfaithful.

The patient's unconscious line of argument ran as follows: "What has my sister done to me? For the sake of a stranger, she has disappointed my sacrificial love and inconsiderately left me alone in solitude. With what thanks am I repaid for having stretched out a helping hand to the little orphan at a time she was so helpless!"

The clearer the picture of her own unhappy fate became in the analysis, the stronger grew the accusations of her sister and the more threatening her remonstrances, until she reached the point of passing the following sentence upon her sister: As a punishment she was to be driven out on the street where she would have landed "anyway" had not her sister, out of love, taken her in.

As we follow the patient's psychic development, we come to see in the symptoms and character changes, despite the shifting picture, a clear consequence of inner events. First, hate and aggression toward the sister, defense against these impulses through compulsive-neurotic mechanisms; then successful over-compensation for this hate through love and tenderness; satisfaction of the injury to her narcissism through identification with the sister; and finally the transformation of the aggression toward the sister into masochistically satisfying sacrifice of herself. Like a red thread there runs through this woman's life a desperate clinging to the beloved object, the sister.

After her final disillusionment with her sister (the latter's marriage) the old conflicts acquired new quantities of aggressive impulse until the psychotic picture was reached. The identification was maintained as well as the masochistic turn against the Ego. The punishment intended for the sister—to throw the guilty one out "on the street," to let her go to her ruin in misery—the patient repeated with stereotyped monotony, now *no longer against the sister* but *against herself,* on one occasion imploring that it be carried out, on another protecting herself in intense anxiety against it. Now we are able to understand to whom this punishment belongs and why the patient was in the habit of maintaining in bitterest self-accusation: "I have deserved nothing else." Her own crimes, those ascribed to herself, were harmless enough; her sister's deed, however, "deserved nothing else" than to be punished in the severest manner.

Deserted by her sister, the patient remained without love-object. It was impossible for her to find a new object for her love since the conditions of her fixation upon her sister had deprived her of any possibility of displacement to new objects. Within herself, she remained bound to her sister. Her psychic energies, no longer capable of being turned to positive use in this connection, suffered the following fate: The withdrawn libido[21] retreated to positions already prepared by her far-reaching identification with the sister. Instead of going out to the external world, the stream of libidinous energy flowed inwardly, to the world within, and narcissistically invested the Ego itself. The narcissistic identification with the sister, which formerly accrued to the sister's benefit, grew stronger and the aggressions and murderous tendencies of hatred toward the sister now turned toward her own identifying Ego. In earlier periods of her life, the patient had still possessed the inner possibility of absorbing the aggressive impulses through reaction-formations (for example, super-tenderness). In those days, the punitive, destructive forces of the inner conscience could still be kept in bounds and bribed, in part through protective measures (compulsive symptoms), in part through masochistic sacrifices. With the "treacherous" behavior of the sister, the patient suffered a collapse of her psychic structure in which hitherto love had performed the binding and supporting function. But now only rage and fury were present, hatred and destruction. For the patient there was nothing left but either to direct the aggressions outward, toward the sister, or repress them and herself suffer the consequences of this repression of hatred. Under pressure of deep (that is, unconscious) inner feelings of guilt, all this aggression, originally directed toward the unfaithful object, was turned toward her own Ego.

Thus, although this self-repudiation, this severe self-accusation of the patient originally applied to the object and was then shifted, the means of struggle remained the same; only the scene of action changed. The Ego now appeared split into two parts. One part swallowed up the introjected object; the second rejected this identified Ego, raged against it, decreed punishments for it. This part, which had now concentrated these aggressions, corresponded to that inward critical tendency we call the Super Ego (unconscious conscience).

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21. *Libido*: a term coined by Freud, denoting sexual energy. Libido comprises, however, not only genital sex but also all the infantile precursors of sex.

We see furthermore that the depressive psychosis is not only a "cry of desperation for love," as Rado called it, but also a cry of desperation for the denial of the inner hate. All depressives are fully ambivalent in their pre-psychotic condition as well, that is, they are chronically under the continuous pressure of simultaneously coexisting tendencies of love *and* hate. It is therefore understandable that many who later become depressive psychotics should show in their pre-psychotic condition definite compulsive-neurotic features, as was already noted in 1908 by Karl Abraham, to whom, next to Freud, psychoanalysts owe so much in the elucidation of this disease. Depressive psychotics are not capable of unequivocal feelings of love because aggression always intervenes in their relation to the beloved object. With depressive psychotics there is a strengthening of the negative, hate-laden component. These people regress to the very earliest stage of development, the so-called "oral" stage, in which cannibalistic elements predominate in the unconscious.

A case of my observation was brought to my attention in a circuitous way: A young man met at a social gathering a young girl who, in the course of the evening, directly offered herself to him. He slept with her. She was frigid and did not allow any petting or preliminary acts, was uninterested in the sexual act, but kept repeating in a flighty manner during the act how much she was admired and sexually desired. The man could not understand her behavior, especially her objection to "petting," since he believed that morally petting was less objectionable than intercourse. When he learned, a few days later, that his so suddenly acquired friend was to be found in a psychiatric sanatorium where she had been committed because of manic psychosis, he severely reproached and blamed himself for it. The irony of the situation was that he did not understand the psychotic condition and yet felt responsible for it. A year later I had the opportunity to observe the psychotic girl in a pre-depressive phase in which she tried to commit suicide. At that time she accused herself of being "good for nothing" since she had masturbated as a child. Interestingly enough, she accused herself only of masturbation, not of promiscuity. According to her, this masturbation was responsible for everything. Especially she had alienated through it her "innocent cousin." The real inner facts were, as is so often true, the reversal of the conscious reverberations. The patient had an orphan cousin two years her senior, who was brought up with her. The two children were deeply attached to

each other. When the patient was five, the girls masturbated mutually, the cousin taking the initiative. The mother discovered them and ordered that they sleep in separate rooms. The hypocritical cousin convinced the mother that the younger girl was the seducer. The mother believed this because some of her daughter's friends had a poor reputation. The patient's hatred was overdimensional: She remembered later having condemned her cousin to death in her mind. What she did amounted practically to "detaching" herself from her cousin, only to be drawn time and again back to the girl. The cousin, obviously a psychopathic personality,[22] was a parasite who later took advantage of the younger girl's adoration. At the age of eighteeen the cousin married a masochistically-tinged Hungarian aristocrat and left the country. A few months later the patient had her first depressive phase.

All of the reproaches which she heaped upon herself were inwardly directed toward her cousin. The introjected cousin was accused of having spoiled the patient's chances in life with the masturbation. The patient believed that she herself did not marry because of the masturbation. Of course, she was unconsciously not blaming masturbation but the underlying oedipal[23] and homosexual connotations[24] and fantasies.

The case was interesting because it showed that the transition between the manic and the depressive phase of cyclothymia[25] did not change the basic conflict. Freud pointed out that the mania is the stage of triumph, in which the humiliated Ego revolts against the cruel inner conscience (Super Ego), nullifies it temporarily, throws off its chains in a sort of slave revolt and ecstasy of freedom. In other words, it is an attempt of the Ego to free itself of the

22. *Psychopathic personality*: a psychiatric term denoting a specific type of neurosis characterized, for instance, by unreliability, lies, stealing (cleptomania). The old term was "moral insanity."

23. *Oedipal fantasies*: Oedipus Complex (Freud) denotes libidinous and aggressive attachment to the parents. The boy at the age of from two to five, goes through a phase in which he desires sexually his mother and hates his father as a competitor. The word "sex" is *not* identical with intercourse. The boy has very fantastic ideas about what is going on mysteriously between his parents. These misconceptions of the child are the contents of his "sexual" wishes. Normally, these oedipal wishes are given up.

24. *Homosexuality*: a perversion denoting love for the same sex. The psychologic structure is complicated. See for a review of literature and the author's personal opinions: Eight Prerequisites for the Psychoanalytic Treatment of Homosexuality (1944) 31 The Psychoan. Review 253. Furthermore: The Respective Importance of Reality and Fantasy in the Genesis of Female Homosexuality (1943) 5 Journal of Criminal Psychopathol. 27.

25. *Cyclothymia*: a psychiatric term for alternating manic and depressive phases in manic-depressive psychosis.

tyranny of the conscience. The accent lies on *attempt,* because the hypomaniac mood[26] just covers depression (H. Deutsch, Schilder). In the case in question, even the manic phase did not remove the old fear of masturbation (The girl refused petting and clitoridian preparatory acts, shifting her compensatory aggression toward the family by permitting intercourse, the adult outlet for sex).

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Clinical experience confirms Freud's assumption that the suicide kills intrapsychically in killing himself also a person who disappointed him and with whom he inwardly identifies. The question remains as to why a person should identify with someone who disappointed him, rather than discarding that individual once and for all. The answer is that by introjecting (identifying with) the disappointer, the contact with the person continues. In other words, *the unconscious identification with the disappointer represents a desperate unconscious attempt to negate the finality of the disappointment.* It also provides a means of overcoming the helpless fury: By "mistreating" the introjected person, the victim takes revenge upon him. True, this revenge is only possible in self-damaging conditions; at bottom the suicide kills himself, whomever he unconsciously imagines that he kills. This makes one suspicious as to whether the revenge and hate motive with resultant feeling of guilt is the decisive one in suicide.

There is an incongruity between the earlier and later statements of Freud concerning suicide. In 1920 he stated:

> "It is possible that nobody has the psychic energy to kill himself who, first, does not at the same time kill another object, with whom he identifies himself, and, second, in doing so turns a death wish against himself which was originally directed against another person."[27]

In 1923 Freud[28] explained once more that two basic instincts, life and death instincts, are operative in every human being. His "Eros-Thanatos" theory assumes that our whole life consists of a fight between two basic instincts—the "life instinct" (Eros) and the "death instinct" (Thanatos). Eros attempts to discharge upon objects in the outer world the tendency of Thanatos, which is originally turned upon the individual himself. What is apparent

26. *Hypomaniac mood*: an abnormal gaiety, a prestage or abortive equivalent of the manic phase of cyclothymia (see footnote 25).

27. Psychogenesis of a Case of Female Homosexuality, Ges. Schr. V.

28. The Ego and the Id, Ges. Schr. VI.

as instinct of destruction is genetically the original death instinct forced into an altered direction by the life instinct. Guided by Eros, the destructive instinct rages outward instead of inward.

Imagine two giants fighting each other: One wants to kill the other. The other tries to divert the destructive energy of the first toward a third party. Imagine further both giants operative as instincts in one personality, and you have in a nutshell the Eros-Thanatos theory. These drives never appear "unmixed." They are combined in quantitatively-varying degrees at different times. There is also an "indifferent narcissistic energy" which can be added to one drive or the other, thus increasing its cathexis. Of course, what we see clinically is never life or death instinct per se, nor even their original mixtures, but only the derivatives of these mixtures. In this sense we can speak of "libido" and "destrudo" (aggression), assuming that each contains mixtures of both drives, libido more of the derivates of Eros, destrudo more thanatic elements, but both admixtures of erotic and thanatic elements. Normally, the life instinct redirects toward outside objects the death instinct which is originally directed toward the Ego. In specific conditions a de-fusion of both instincts takes place and the death instinct rages against the Ego. To quote Freud:

> "Let's turn to depressive psychosis. We find that the over-powerful Super Ego (inner conscience) . . . rages against the Ego with merciless violence, as if it had taken possession of all the sadism the person has at his disposal. According to our viewpoint of sadism, we would say that the destructive component has placed itself in the Super Ego and is directed against the Ego. What now reigns in the Super Ego is like a pure mixture of death instinct, and often enough it does succeed in driving the Ego to death, unless the Ego unburdens itself of its tyrant by turning into mania."[29]

Freud explains also that the more a person restricts his inner aggression, the more severe does his Super Ego become.

How can we reconcile the two approaches? In the first, stress is laid on the fact that the Ego can be driven to self-destruction by the inner illusion of killing the tormenting disappointer. In the second, the decisive factor is the de-fusion of instincts, with the result that the Super Ego usurps the whole energy of the death in-

29. Id. at 598-599.

stinct, actually driving the Ego to death. True, both approaches assume inner guilt to be the motor which starts the procedure.

I am personally of the opinion that the decisive element in suicide is the predominance of death instincts, *changing the afflicted person into an exquisite seeker of self destruction.*[30] I believe furthermore that the overdimensional feeling of guilt, because of death wishes toward the introjected disappointer, is the *covering cloak of pseudo-aggression*[31] *disguising this inner passivity.* In other words, what really drives the suicide to death is not his inner guilt but the defusion of instincts, leaving the death instinct no longer attenuated by life instinct. But even then the *illusion of pseudo-aggression* must be maintained—therefore the unconscious fantasy of killing the disappointer. One could say that the suicide must convince himself even in death that he is capable of aggression.

In a short story by the French writer, Villiers d'Isle Adam, an aristocratic French family of the time of Richelieu is confronted with the fact that a young member of the family has taken part in a rebellion against the King and Cardinal, has been arrested, found guilty, and condemned to die on the scaffold. The honor of the family is at stake should the condemned not die proudly and defiantly. To bolster the morale of the unfortunate man, he is sent word by his family that an attempt will be made to save him, and that he is to look for a sign from a certain window visible from the place of execution. He is told that the attempt will be made in the last few seconds, and not to lose courage. The hoax works, and the man dies proudly. Mutatis mutandis, the suicide fools himself with pseudo-aggression toward the introjected object similarly. Instead of hope, aggression is the prop.

Another set of facts indicates the same psychological picture of suicide. It has been repeatedly observed that the choice of form of suicide has an unconscious libidinous meaning. As an example

30. I expressed that opinion first in Problems of Suicide (1946) 20 The Psychiatric Quarterly Supp. 261. See also my book, The Battle of the Conscience (Washington Institute of Medicine 1948) c. 5.

31. *Pseudo-aggression*: a term denoting a self-damaging action under the disguise of aggression. If a neurotic employee, for instance, provokes his superior mercilessly, the naive observer would say that the man acts "aggressively." Psychologically, the situation is quite different: his "psychic masochism" (see note 17, supra) forces him unconsciously to construct a self-damaging situation. Only the tools and the technique of achieving it are "aggressive." This palimpsest is called pseudo-aggression to distinguish it from real aggression which wants to harm the enemy exclusively. For a differentiation of real and pseudo-aggression, see the author's: Differential Diagnosis Between Normal and Neurotic Aggression (1946) 1 Quart. Review of Psychiatry and Neurology 1.

a case of Mary Chadwick can be adduced: A woman who, as a little child, was raped by a friend of her father, repeatedly tried suicide. She always chose a method which involved falling—being run over by a car, falling down stairs, et cetera. She was symbolizing the "fallen woman." A great amount of examples has been amassed by different authors stressing that libidinous symbolic motive in suicide. All of these elements seem to me unimportant[32] in the suicide—they are the bait the inner conscience gives to lure the victim into self-destruction.

K. Menninger[33] distinguishes in suicide three elements: the wish to kill, the wish to be killed and the wish to die. He states: "We have presented the thesis that suicide is a gratification of self-destructive tendencies which, upon analysis, appear to be composed of at least two elements—an aggressive element—the wish to kill—and a submissive element—the wish to be killed. In addition, it is postulated that a wish to die may be present to a variable degree for which, however, no definite psychological evidence can be offered."

To sum up: The suicide of the introjection type is a person laboring under deepest feeling of guilt because of his over-dimensional *psychic masochism.* To counteract this reproach, *pseudo-aggression is mobilized*—the fantasy of killing the disappointer. The disappointment is always self-provoked, by choice of and attachment to the disappointing person. The feeling of guilt is *shifted* from the masochistic act to a pseudo-aggressive one.[34]

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32. Many libidinous tendencies projected upon suicide belong in this—as I believe, dynamically unimportant—category. They are often overstressed. Zilboorg pointed out that in some cases of suicide an identification with a person already dead takes place [(1935) 21 Int. Z. f. Psychoan. 102] and the actual suicide expresses unconsciously the wish to be reunited with the dead person. B. Warburg described a case of a deformed and gonorrhoic girl in whom suicide meant also to be reborn and emerge unblemished; besides feeling of guilt this "suicidal attempt not only gratified her heterosexual but also her aggressive homosexual wishes." Suicide, Pregnancy, Rebirth (1938) 7 The Psychoan. Quart. 490.

33. Menninger, op. cit. supra note 12, at 389-390.

34. I am not quite sure but have the impression from some not too clear passages in K. Menninger's "Psychoanalytic Aspects of Suicide" that Menninger, too, came close to the assumption that the unconscious erotic gratifications in suicide, which he emphasizes specifically (masochism, erogenized submission, symbolic erotic gratification in choice of technique) are compensatory. He does not say so expressis verbis and states only: "We also know, however, the curious propensity of the erotic elements, the sexual element of the life instinct, for making the best of a bad situation and endowing every object relationship with some of its saving grace. Hence, in any attack upon an enemy, however strong the wish to kill, we must expect varying quantities of erotic satisfactions." (Id. at 379.) This gives more the impression that because of the chronic duality of destructive and libidinous tendencies, the latter must appear, too. In any case, if one goes one step further, the compensatory character is obvious. Another passage of Menninger's paper (Id. at 379.) points in this direction; in discussing

II. The Hysteric "Dramatization" Type

Clinical experience proves that the majority of suicides are depressive psychotics, whose illness is detected during lifetime, or, more often, has remained undiagnosed. The question arises as to whether all suicides belong in this category. There seems to be agreement in the view that other types are possible (Freud, Federn, Menninger, Zilboorg).

The most important group among these other types is the hysteric. In my personal opinion, the hysteric suicide is based on a specific type of "magic gesture." There are different types of "magic gestures;"[35] the one important in suicide is one which I called the "negative magic gesture." The term denotes an *unconscious* dramatization of how one does *not* want to be treated. It constitutes a bitter unconscious irony directed against an authoritative person in early childhood. An example of this type: A patient while waiting for her appointment made movements with her mouth reminiscent of a wild animal snatching at its victim. I asked her: "Do you imitate the lion in Metro-Goldwyn-Meyer's pictures?" Analysis showed that in this gesture she was playing the role of her own "devouring" mother, thereby showing up her mother, whom she accused of all possible crimes, in a caricature.

"Magic gestures" of this type presuppose a three-layer structure: 1. unconscious masochistic attachment toward the person in childhood, as the end-result of the infantile conflict; 2. objection by the inner conscience (Super Ego) to this enjoyment of inner passivity, forcing the unconscious Ego to furnish a defense mechanism in the form of the pseudo-aggressive alibi, "I hate my mother (father)"; 3. objection by the Super Ego to this defense, too, with the result that even the defensive pseudo-aggression is modified into "I'm just showing them how mean they acted." The whole process is, of course, *unconscious.*

The hysteric[36] suicide makes use of this technique. Coupled with the "magic gesture" is the infantile unconscious misconception

a patient's unconscious wish to be homosexually attacked he uses projection as defense in the reconstruction: "Thus, it is not I who play tricks upon the analyst, it is he who plays tricks upon me. He attacks me. Therefore I hate him, I want to kill him, I do kill him. But for killing him I also feel guilty and must suffer a like fate myself." Here the Freudian explanation of paranoic projection in "The Schreber Case" (Coll. Pap. III. p. 388) is referred to.

35. See the writer's: The Problem of Magic Gestures (1945) 19 The Psychiatric Quarterly 295.

36. *Hysteria*: an old psychiatric term denoting a specific type of neurosis. In a dim realization that sexual problems are involved, physicians of olden times coined the term with the etymology of womb.

of death, which, for the child, lacks finality. This is easily observable in children to whom "death" is often represented as "going away," "taking a long journey," et cetera. Children's play bears this out: One patient as a child played with his brother the game of "being dead." He would command, "Now you are dead!" and his brother would stretch out motionless, holding his breath. After a few seconds would come the counter order, "Now you are alive again!" It is obvious that the play had—at least superficially—an aggressive connotation—death wishes against the brother.

All of this indicates that hysteric suicide—provided the hysteric superstructure does not cover an "introjection" mechanism—is not too seriously intended. There is no doubt that a severe inner guilt conflict is involved, too. In such cases there are discernible death wishes or incest phantasies which, because of the inner "poena talionis"[37] boomerang in the form of self-punishment. Let us take two clinical examples:

Case I. Mr. A, a young man of twenty-four, had for many years a severe conflict with his father, a wealthy and tyrannical individual who wanted to force his son into a commercial career. The boy refused, left home, became attached to a radical party, thus mildly compromising his father but infuriating him beyond every logical reason. To complicate matters, the boy married, against his father's wishes, a girl "beneath his own station." This resulted in a complete severance of relations between father and son. When the young man became ill with an acute tuberculous condition, the father refused to help him as long as he did not renounce his wife. The couple agreed to an official separation to enable the boy's transfer to a sanitarium. After long months his condition improved, and he started once more his contact with his wife. The father discovered this and refused even to see him. A few days later the son went to a hotel and swallowed an overdose of sleeping pills. Immediately afterward he started frantic telephone calls to his wife and family physician. His father still said: "To hell with him! Why doesn't he commit suicide more successfully?" and refused to pay the doctor's bill.

The analysis of the young man started after his release from the hospital a few weeks after his suicide attempt. It showed that his hatred for his father was the covering cloak for his deep attachment to him. The boy was a typical example of regression to the

37. *Poena talionis*: The "eye-for-an-eye" conception.

"negative Oedipus," which consists of feminine identification. Unconsciously he identified with his mother and wanted to be sexually "mistreated" by his father, since, as a child, he believed that parental congress consisted of sadistic attacks on the part of the father upon the mother. After a short-lived "positive Oedipus," he renounced his libidinous wishes toward his mother and hatred of his father because of an overdimensional "castration fear,"[38] and took refuge in passivity by identifying with his mother.

This inner passivity was counteracted by a strong feeling of guilt, which forced him to establish an inner defense—pseudo-aggression. This explains his acts of "aggression" toward his father (refusal to take up a commercial career, escape from home, political activity and marriage against his father's wishes, et cetera). All of these actions had a double meaning unconsciously: They gave him the illusion of being aggressive as a defense against his masochistic submission *and* at the same time provided the masochistic pleasure of being "mistreated" (with its above-mentioned sexual connotation) by his father—a perfect neurotic set-up.

It also became clear that the patient was inwardly uninterested in his wife, that he was just using her as a tool against his father and for the inner defense of being a "he man."

The conscious motivation of his suicide was: "Father will feel sorry after my death." In other words, consciously it was an act directed against his father. Unconsciously the situation was quite different. The suicide represented, first, a masochistic "magic gesture": "The only thing you can get from father is rejection. He lets you starve and drives you to suicide. True, he would perhaps provide poison." In attempting suicide he demonstrated in an ironic accusation his father's "meanness." That he himself was the victim and not his father did not occur to him.

The suicide in this case was an unconscious wooing of the father. It was an attempt to make him understand that the son was willing to give up everything to get the old man's forgiveness and "love." Asked why he made the telephone calls immediately after taking the poison, he replied that new hope came over him when it occurred to him "in a flash" that his father would see the "serious-

38. *Castration fear*: an analytic term denoting the boy's fears concerning the integrity of his genitals. Since the child masturbates with veiled oedipal fantasies (see note 23, supra), it fears that the father will punish him on the same organ which he has forbidden him to touch. Normally, castration fear forces the child to abandon his oedipal wishes.

ness of the situation." Asked whether that included acceptance of the daughter-in-law, the patient said that he doubted that even at that moment. In other words, the young man was willing to sacrifice the girl.

Once more we see, under the disguise of pseudo-aggression, masochistic submission. The question as to whether simulation was involved can be answered in the negative. A deep inner conflict was involved.

Case II. A woman of forty, a widow, had an affair with a somewhat younger man. One day the lady's eighteen year old daughter declared that she intended to marry her mother's lover. Excited quarrels between the two women, in the course of which the daughter demanded that her mother separate from her lover, culminated in a suicide attempt on the part of the daughter. Her mother was, afterwards, on the verge of suicide, too. The analysis of the mother, which followed, yielded the fact that a photographic unconscious reproduction of her own childhood had taken place. Many years previously, it developed, she had found herself in an unusual situation of conflict. Her mother (the grandmother of the girl who attempted suicide) had a lover, of whom the patient was very jealous. The energetic and unscrupulous grandmother apparently wished to get rid of her lover, and suggested to her daughter that she should marry him. The daughter was indignant and at the same time overjoyed. Although it was never officially admitted that it was her mother's lover whom she was to marry, it can be understood that she found the proposal unsuitable. But since this marriage represented a realization of infantile Oedipus wishes (it was clear that her jealousy of her mother's lover was in itself a repetition of the jealousy of her father), she agreed, without, of course, suspecting her unconscious motive. The marriage was very brief and unhappy. The husband was brutal, infected the young woman with gonorrhea, had relations with other women, and died, deeply mourned by the patient, shortly after the birth of her daughter. The patient clung to this child with a remarkable combination of hate and love. As the girl grew up, she brought her indirectly into contact with her own lover. This took place unconsciously, but none the less effectively. She constantly brought the "young people" together, although she was consciously very jealous. A certain scene bears this out. While the "young people" played duets on the piano in the music room, the mother put on her glasses and darned stockings. She thus enacted the old lady chaperoning the "chil-

dren." She was not conscious of this, for when the daughter "to her astonishment" fell in love with her lover, she was indignant. The behavior of this woman is incomprehensible without the assumption of unconscious guilt feelings. "You snatched away your mother's lover, and as punishment your daughter will do the same to you." It was certainly no accident that the daughter fell in love with her mother's lover. This Oedipus relation continuing through three generations is a classic example of the operation of these unconscious attitudes.

The suicidal ideas of the mother could be analyzed. The guilt pertained to the oedipal period, when she had wanted to take her father away from her mother. Interestingly enough, the guilt was not relieved through her mother's invitation to marry her lover; the guilt was already established. The reproachful "magic gesture" was discernible, directed toward the mother: "You forced me into a marriage, and now my child takes revenge on me." Behind this pseudo-aggression self-destructive-masochistic tendencies were clearly visible.

K. Menninger was the first to point out the paradox that many a suicide does not want to die:[39] "Anyone who has sat by the bedside of a patient dying from a self-inflicted wound and listened to pleading that the physician save his life which only a few hours or minutes before he had attempted to take, must be impressed by the paradox that one who had wished to kill himself does not wish to die . . . One gets the impression that for such people the suicidal act is sometimes a kind of insincere play acting and that their capacity for dealing with reality is so poorly developed that they proceed as if they could actually kill themselves and not die. We have reason to believe that a child has some such conception of death: that it is a going away and that for such going away there is often returning . . . ."

III. Miscellaneous Types

Not all persons who commit suicide are depressive psychotics or neurotics of the hysteric type. And still, the majority of all suicides are depressive psychotics. In general A. A. Brill's statement is analytically generally accepted: "I do not think I am exaggerating when I assert that probably *85 to 90 per cent* of all suicides belong to the depressive type of this disease [manic-depressive insanity]."[40]

39. See Menninger, op. cit. supra note 11, at 387.
40. Fundamental Concepts of Psychoanalysis (1921) 262.

P. Federn[41] stressed in 1928 that in his opinion two groups are especially prone to suicide—manic depressive and addicts,[42] whether they are, in addition, hysterics, obsessional neurotics,[43] psychoasthenics,[44] or do not show any clearcut neurosis. Federn is of the opinion that suicide may be the final destiny of a completely normal person.

In a paper[45] read at the Thirteenth International Psychoanalyst Convention in Luzerne in 1934, G. iZlboorg stated: "1. Not all depressive psychotics tend to commit suicide; 2. not only depressive psychotics tend to commit suicide, since one finds suicide also in cases of schizophrenia, obsessional neurosis, hysteria; 3. a series of suicides has the precise stigma of practically uncontrollable instinctual impulses,[46] without reference to what nosologic group they belong, even in so-called normal individuals." Zilboorg claims further that not all suicides can be subsumed under Freud's classic formula of the introjection type, and that some suicides are the pathologically dramatized expression of repetition of a form of mourning which in its turn stems from the primitive ceremonial killing at funerals. Suicide was originally a ritual, a ritual-murder —killing of the old, later suicide of the old and sick; killing, later suicide of the wives and slaves of a deceased chief of a clan.

In a later paper[47] Zilboorg advocates "an entirely different, nonclinical approach" based on ethnological studies:

> "One may state, therefore, that a suicidal drive is not dependent on or derived from any traditional clinical entity found in present-day psychiatric nosology; it is to be viewed rather as a reaction of a developmental nature, which is universal and common to the mentally sick of all types and probably also to many so-called normal persons. The very universality of the reaction, and particularly of some of its outstanding characteristics, such as oral incorporation, spite, and identification with

41. Suicide-Prophylaxis in Psychoanalysis (1928-1929) 3 Z. f. Psychoan. Pädagogik 379.

42. *Addiction*: comprises alcoholism morphinism, cocainism, et cetera.

43. *Obsessional neurosis*: a specific neurosis in which obsessions and compulsions are predominant.

44. *Psychasthenia*: a specific type of neurosis.

45. Summary published in (1935) 21 Int. Z. f. Psychoan. 101.

46. Zilboorg mentions that the active suicidal impulse is especially strong in individuals who identify unconsciously with a person who at the time of completion of this identification is already dead. In these cases the wish to die corresponds to the desire to be reunited with the dead person.

47. Differential Diagnostic Types of Suicide (1936) 35 Arch. Neurol. & Psychiat. 270.

> the dead, leads one to suspect that one may be dealing with an archaic form of man's response to his various inner conflicts, and it would prompt one to seek an answer to the problem in the study of primitive races and their reaction leading to suicide."

There is no doubt in my mind that the great majority of suicides belong to the introjection and hysteric types. True, though, an infinitesimal percentage has a different etiology. For instance, there are schizophrenics[48] of the paranoid type[49] who project their Super Ego outwardly and hear voices commanding them to kill themselves. I observed a patient of this type who repeatedly attempted suicide while in a psychiatric sanitarium. In moments of discernment the patient claimed that he understood that these voices were a symptom and sign of his disease, since "they never give me advice as to where to get the knife to cut my throat. If the voices were real, they would have provided a knife."

In obsessional cases suicide is an extreme rarity. Freud was of the opinion that obsessional (compulsive) neurosis was practically immune against suicide.[50] Zilboorg[51] believes that some severe cases of compulsive neurosis and some addicts are capable of committing suicide in a momentary impulse of spite. This is paralleled by Zilboorg to the behavior of Indians of North and South America, who before or immediately after being taken prisoner by white soldiers killed themselves by the hundreds and thousands.

In any case, obsessional neurotics are not the typical material for suicide,[52] and Freud is undoubtedly clinically correct in his opinion that these neurotics are more or less immune against it.

That addicts are endangered by suicide is clinically provable. The reason is obvious: They are orally regressed[53] and are genetically near to depressive psychotics.[54]

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48. *Schizophrenia*: a specific type of psychosis.

49. *Paranoid type* of schizophrenia: a schizophrenic psychosis in which ideas of persecution are predominant.

50. The Ego and the Id, Ges. Schr. VI. 399.

51. Id. at 101.

52. The problem of obsessional neurosis has, in my opinion, a more complicated substructure than is generally assumed. See the writer's papers, Two Forms of Aggression in Obsessional Neurosis (1942) 29 The Psychoan. Review 188 and The Leading and Misleading Basic Identifications (1945) 32 The Psychoan. Review 323.

53. *Oral Regression*: the basis of the most complicated type of neurosis.

54. For a compilation of analytic literature and the writer's personal opinion on the subject of alcoholic addiction, see Clinical Contributions to the Psychogenesis of Alcohol Addiction (1944) 5 Quart. Journal of Studies on Alcohol 434.

I doubt very much whether suicide occurs in normal people. The statement to the contrary is not borne out by clinical facts.

Despite some attempts to revise[55] Freud's findings on suicide, the majority of analysts believe—as the previously quoted statement of Brill illustrates—that "85-90% of all suicides belong to the depressive type."

IV. Detection of Simulation in Suicide

Simulation of suicide occurs relatively seldom, and the layman is more suspicious of that event than clinical experience seems to warrant. Since such cases do occur, the legal aspect justifies the working out of a series of detective measures.

Confronted with a case of suicide, the psychiatrist will search for the following indications:

1. Does the case belong in one of the two main groups (introjection type and hysteric dramatization type)? Are there any indications of a manic-depressive psychosis or hysteric neurosis?

2. Did the suicide candidates have the reasonable chance, known to him *beforehand* that somebody might intercept him during the suicide attempt?

3. Does the case history indicate that the suicide candidate underwent in previous years a series of operations or was the victim of repeated accidents?

4. Were there serious, *unconsciously self-provoked,* financial losses?

5. Is there a serious discrepancy between the official rationalization given for the suicide attempt and the death-seeking solution?

A few explanatory remarks are in order:

Ad 1. Manic-depressive psychosis is often overlooked. The symptoms and signs are not too rarely neglected, being met with "common sense" advice. The correct diagnosis can be made in general only by a psychiatrist.

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55. See Zilboorg, Suicide Among Civilized and Primitive Races (1936) 92 Am. Journal of Psychiatry 1347, 1356. "If we turn now to purely clinical observations, we find that the old point of view, according to which depressive psychoses have more or less monopolized the clinical right to commit suicide, requires substantial revision."

Ad 2. The end effect—death—does not give any indication as to whether or not simulation was attempted. If, for instance, a woman having a conflict with her husband turns on the gas jet five minutes before he is expected home, with the purpose of "impressing" him, and the outpouring gas makes her unconscious because by chance her husband is late, the simulation may end in death.

Ad 3. A certain predilection for operatons, diseases, or repeated accidents with the unconscious expectation of death is sometimes encountered and gives a clue. Menninger stressed this fact repeatedly: "There are such things as unconscious suicides—'accidents' and diseases brought on by the patient with an unconscious motive."[56] S. Lorand published a case of suicide in which Miss X,[57] a young girl, underwent the following operations in the years preceding her suicide: gallbladder, mastoidectomy, appendectomy, exploratory laparotomy after a sudden collapse with no diagnosed reason, extrauterine pregnancy, repeated abortions, et cetera. It is furthermore analytically known that many deadly accidents of mountain climbers belong in the group of unconscious suicide.

Ad 4. The outer world accepts as sufficient rationalization for suicide financial losses. It thus often confuses the rationalization with the real reason, since it is analytically known that in many cases the financial collapse is unconsciously self-provoked and self-intended. Menninger is correct in stating that many people who commit suicide "began their self-destruction" long before the actual event.[58]

Ad 5. Typical of all neurotic conflicts is the fact that an *objectively* commonplace conflict appears to the neurotic *subjectively* insoluble. The reason, as Freud proved, is that the actual conflict occupying the conscious Ego is aggravated by repressed infantile conflicts. The sufferer is fighting shadows and always strikes in the wrong direction. This explains why the actual conflict, whose practical solution seems quite simple to a healthy person, becomes a Gordian knot to the neurotic. The external denial becomes an inner, unconscious one. Since the neurotic knows nothing of the unconscious reinforcement of his commonplace conflict, he clings to more or less suitable rationalization. That he has provoked or at least "misused" the actual conflict as a hitching post for unconscious repetition of infantile conflicts is unknown to him.

56. The Human Mind (3 ed.) 125.
57. The Suicide of Miss X (1929) 3 Z. f. Psychoan. Pädagogik 431.
58. Id. at 24.

The result is twofold: First, the suicide believes his external conflict to be insoluble and the real reason. Second, the outer world follows him and asks for but a suitable rationalization. Thus, disappointment in love, financial losses, poverty, sickness, fear of humiliation, are accepted as reasons for suicide. Both conclusions are in distinct contradiction to psychiatrically clarified facts.[59]

V. The Question of the "Sound Mind" in Suicide

State laws of forty-four states in the United States do not consider suicide as a crime, in contradistinction to the English law, which classifies it as felony. In four states only—North and South Dakota, Washington, and New Jersey—is attempted suicide a crime.[60] By the statutes of some states, however, it is a crime to induce or assist another to kill himself. In some cases the courts have refused to class suicide as murder; in others there have been convictions for murder in the first or second degree. The New York State Penal Code rules: "A person who wilfully, in any manner, advises, encourages, abets, or assists another person in taking the latter's life is guilty of manslaughter in the first degree."[61] In the well-known Illinois case of *Burnett v. People*[62] it was decided that inducing another to commit suicide by taking poison was sufficient to warrant a conviction for murder in the first degree.

Of great importance are the civil aspects, especially claims against insurance companies. A very important medicolegal problem arising constantly in life insurance cases is this: Should the deceased be considered to have been of "sound mind" at the time of the suicidal act? If so, there can be no recovery under the life insurance policy unless it has been in force so long as to have become incontestable on the grounds of suicide. (Most of the life insurance companies have inserted a clause in their policies providing that if death is due to suicide within the first year, or two years, of the life of the contract, payment will be limited to the premiums that have been collected, to the legal reserve, or to some portion of the

59. Mary Chadwick collected seven cases in her paper, Fantasies about Suicide (1929) 3 Z. f. Psychoan. Pädagogik 409, contrasting the conscious, banal reasons with the unconscious reasons elucidated in analysis of these patients. Similar material, combined with literary examples, is to be found in Angel Garmas: Psychology of Suicide (1937) 23 Imago 63. See also Friedmann, Sur Suicide, Bibliothèque Psychoan., Denoel et Steele (Paris 1935). This paper contains also a valuable discussion relating to the older psychiatric literature which blamed suicide on constitutional factors.

60. Dublin-Bunzel, To Be Or Not To Be (1933) 254 et seq.

61. New York Penal Code § 2305.

62. 204 Ill. 208, 68 N. E. 505, 66 L. R. A. 304, 98 Am. St. Rep. 206 (1903).

policy, as the case may be. The most usual arrangement is a two year clause providing for the return of the premium, without interest, in the event of suicide.)[63] Self-destruction by a person of "sound mind" will not only forfeit many insurance policies, but in the Armed Services is considered to be such misconduct as prevents the deceased from being in line of duty. The result is that next of kin lose their right to a pension.

The question hinges on the definition of "sound mind" and legal responsibility. Here the difficulty starts, because the legal and medico-psychiatric definition of what constitutes an unsound mind differ. The *legal* yardstick is one hundred years old—the M'Naghten rules. These rules state:

> " . . . to establish a defense on the ground of insanity, it must be clearly proven that, at the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know he was doing what was wrong."[64]

The "Rules" labor under the illusion—to reduce them to their simplest common denominator—that a psychotic person is "crazy" in a *popular* sense of the word. The popular conception of mental disease envisages a raving maniac devoid of all reason. The *scientific* conception of psychosis is quite different: A person may appear to the layman quite rational and still be under the influence of a psychosis. Let's take the following example: A wealthy businessman confronted with bankruptcy commits suicide, seemingly in order to enable his family to have the benefit of large insurance policies before the latter lapse for non-payment of premium. The man acts in a calculated manner; the motive for suicide seems rational and simple—avoidance of humiliation and wish to provide for his family. Psychiatric investigation, however, would reveal that the financial difficulties were unconsciously self-provoked, that the man had, some time before, a car accident, for instance, which was unconsciously self-provoked too, that he suffered from depression, in reality, from a depressive psychosis. No layman would concede or detect the existence of his psychosis, because the motive is "rational" and the man himself made a "normal" impression.

63. Dublin-Bunzel, op. cit. supra note 60, at 258. It is, by the way, interesting that the statistics of great insurance companies prove that "where suicide was the cause of death, policies had an average length of thirteen years." Id. at 261.

64. The M'Naghten Case (H. L. 1843) 10 Clark & Finelly 200, 210.

Even more complicated are neurotic cases of suicide. Here the situation is quite hopeless, since neurosis is popularly considered to be no sickness at all.

Now, one could object that even the layman can understand that even though a person has apparently been well oriented in his behavior shortly beforehand, he has been under psychological stress of such degree that immediately prior to attempted suicide he has reached a stage of "utter confusion," where he loses much of his "volitional control." One could mention that fact that even the English law seldom applies the felony clause:

> "The legal issues involved in self-inflicted death are generally settled nowadays in England by terming the case one of 'non compos mentis'. Since the law still regards suicide as a crime in a sane person, the coroner's jury very frequently returns this finding to avoid the infliction of any penalty or stigma. Thus out of 4846 inquests on suicides in the year 1928, the verdict of 'felo de se' was returned in only 88 cases."[65]

All this does not help. The real facts are that no person of "sound mind," to use the popular misnomer, commits suicide. Suicide starts long before the actual act of self-destruction. *All suicides act under the pressure of unconscious forces*[66] and are, psychiatrically speaking, *no more or less responsible for the act than is a person for having cancer.* They are sick people, and psychiatric treatment started in time could prevent many, though not all, suicides.

Every case of suicide has its peculiarities and must—in case legal or civil claims result—be psychiatrically studied, inasmuch as in some, though few, cases, simulation may be involved.

65. East, Suicide from the Medico-Legal Aspect (August 8, 1931) British Medical Journal, quoted by Dublin-Bunzel, op. cit. supra note 60, at 253.

66. For a connection between suicidal and criminal cases, see the writer's Suppositions About the Mechanism of Criminosis (1943) 4 Journal of Criminal Psychopath. 215.